STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. building 00		COMPLETED	
		155364	B. WING		10/10/2012	
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER		12101 l	_IMA RD		
BYRON I	HEALTH CENTER		FORT \	WAYNE, IN 46818		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
	This wish	ion - Documbification and	F0000	T. D. (0		
		for a Recertification and	F0000	This Plan of Correction is the		
	State Licensur	e Survey.		Center's credible allegation of compliance. Preparation and/	l l	
		0.1.1.000.500		execution of this plan of	<u> </u>	
	-	October 1, 2, 3, 4, 5, 9		correction does not constitute		
	and 10, 2012			admission or agreement by the		
				provider of the truth of the fact	l l	
	Facility numbe			alleged or conclusions set fort the state deficiencies. The pla	l l	
	Provider numb			of correction is prepared and/o		
	AIM number:	100273280		executed because the provision		
				of federal and state law require		
	Survey team:					
	Christine Fodre	ea, RN, TC				
	Julie Wagoner	, RN				
	Tim Long, RN					
	Census bed ty	pe:				
	NF:	109				
	SNF/NF:	2				
	Residential:	43				
	Total :	154				
	Census Payor	type:				
	Medicare:	1				
	Medicaid:	109				
	Other:	44				
	Total:	154				
	i otal.					
	Residential Sa	mple: 7				
		1				
	These deficien	cies also reflect state				
		n accordance with 410				
	IAC 16.2.					
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY MPLETED 10/2012		
	PROVIDER OR SUPPLIE HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818					
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
	Quality review Williams, RN	10/16/12 by Suzanne						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42511

Facility ID: 000255

If continuation sheet

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155364		A. BUILDING	00 	COM	COMPLETED 10/10/2012	
			B. WING STREE	T ADDRESS, CITY, STATE, Z			
NAME OF P	ROVIDER OR SUPPLIER		1210	1 LIMA RD			
BYRON I	HEALTH CENTER		FOR	T WAYNE, IN 46818			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION)	CORRECTION	(X5)	
PREFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO T	THE APPROPRIATE	COMPLETION DATE	
F0162	483.10(c)(8)	LSC IDENTIF TING INFORMATION)	TAG		<u>, </u>	DATE	
SS=A	LIMITATION ON	CHARGES TO					
	PERSONAL FUN						
		not impose a charge against					
	•	Is of a resident for any item nich payment is made					
		r Medicare (except for					
		tible and coinsurance					
		acility may charge the					
	•	ested services that are han or in excess of					
	•	in accordance with					
	§489.32 of this ch	napter.					
	/This does not off	foot the gradition on					
	`	fect the prohibition on or items and services for					
		as paid. See §447.15,					
	which limits partic	cipation in the Medicaid					
		ders who accept, as					
		ledicaid payment plus any urance, or copayment					
	· ·	lan to be paid by the					
	individual.)						
	During the course	e of a covered Medicare or					
		cilities may not charge a					
		ollowing categories of items					
	and services:						
	Nursing services this subpart.	as required at §483.30 of					
	-	as required at §483.35 of					
	this subpart.						
		ram as required at					
	§483.15(f) of this						
	Room/bed mainte	hygiene items and					
		red to meet the needs of					
	residents, includi	ng, but not limited to, hair					
		comb, brush, bath soap,					
		s or specialized cleansing cated to treat special skin					
		tht infection, razor, shaving					
		,g				1	

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Event ID: Q42511

Facility ID: 000255

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	OF CORRECTION IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/10/2012			
	PROVIDER OR SUPPLIER HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION			
	cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry. Medically-related social services as required at §483.15(g) of this subpart. Listed below are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid: Telephone. Television/radio for personal use. Personal comfort items, including smoking materials, notions and novelties, and confections. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare. Personal reading matter. Gifts purchased on behalf of a resident. Flowers and plants. Social events and entertainment offered outside the scope of the activities program, provided under §483.15(f) of this subpart. Noncovered special care services such as privately hired nurses or aides. Private room, except when therapeutically required (for example, isolation for infection control). Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by						

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Event ID: Q42511

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLI	ETED
		155364	B. WIN			10/10/2	2012
			B. (11)		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	L			IMA RD		
BYRON I	HEALTH CENTER				VAYNE, IN 46818		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP			(X5)
PREFIX	l `	CY MUST BE PRECEDED BY FULL				re	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	§483.35 of this su	лорап.					
	his or her represesservice not requested facility must not reher representative services as a concontinued stay. Tresident (or his or requesting an iter charge will be made charge for the iter charge will be. Based on interreview, the fact of 8 resident and not charged for covered by Me. Finding includes 1. Review of the Accounts for Review of the Conducted on indicated the analysis indicated the fact of the indicated the fact of the indicated the respecific items, shopped for the the itemized list on the resident	ne Resident Funds esidents #67 10/04/12 at 10:45 A.M., ccounts had ndrawals made view with Employee # hief financial officer) acility social service for the residents. She esidents requested and the facility staff e items. She indicated tts were not specified	F01	62	F 162 Limitations on Charge to Personal Funds What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice. The Resident has be reimbursed the facility cost of items purchased to her resident fund account. How other residents having the potentiat to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. All residents who choose to purchase their own care items have the potential to be affected by this practice. Beginning immediately, if the facility shop for the purchased items, the receipt will be turned into the business office for reimbursement. If the family shops for the resident, they will need to turn in the receipt to the business office for the	een nt al e ed	11/08/2012

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If continuation sheet Page 5 of 28

STATEMEN	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION				ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLETED	
		155364	B. WIN			10/10/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1			
DVDONI	HEALTH CENTER		12101 LIMA RD FORT WAYNE, IN 46818				
BIRONI	HEALTH CENTER			FORT	VATINE, IN 40616		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	kept and the fa	cility was changing the			reimbursement. What measu	res	
	•	going to start itemizing			will be put into place or what		
	the "shopping"				systemic changes will be ma	de	
	l the shopping	Withdrawais.			to ensure that the deficient		
					practice does not recur. The		
		resident fund account			business office, activity, and		
	for Resident #6	87, who received			social services staff will be		
	Medicaid moni	es, indicated a			in-serviced about the regulatio	ns	
	"shopping" with	ndrawal made on			regarding reimbursement for		
		"body was (sic) and			residents when personal care		
		ding to the accounts,			items are purchased. As	h -	
	•	•			reminders for the families, will		
		drawn, the items			put in the family newsletter on quarterly basis that	a	
	l •	d \$1.12 in change			reimbursement is available for		
	placed back int	to her resident fund			personal care items when a		
	account. Interv	view with Employee			receipt is provided. For new		
	#12, the CFO,	indicated she did not			admissions, residents and		
		ent was only charged			families will be informed of this	3	
		n cost for the items			practice. As reminders for		
		the cost of the same			residents, this practice will be		
	l ·				reviewed quarterly at resident		
	items provided	by the facility.			council meetings. How the		
					corrective action(s) will be		
	Interview, on 1	0/04/12 at 1:20 P.M.,			monitored to ensure the		
	with the Social	Service Director (SSD)			deficient practice will not rec	ur	
	indicated the re	esidents themselves			i.e., what quality assurance		
	were responsib	ole for bringing the			program will be put into place		
	I	ffice and requesting			The Director of Resident Care	I	
	•	be reimbursed, even if			and/or CFO will audit 10% of the	ne	
		· ·			receipts turned in monthly to ensure proper reimbursement	to	
		had shopped and			the residents has occurred.	.0	
	l ·	items for the resident.			Results of the audit will be sha	red	
	She indicated t	he facility kept all the			at the monthly QA meeting.		
	receipts for the	shopping for each			Please see attachment #7		
	resident. She	indicated no resident					
		he reimbursement for					
		though they were					
		-					
	i nouned upon a	dmission of the policy.					

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If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155364	A. BUI	LDING	NSTRUCTION 00	(X3) DATE S COMPL 10/10/	ETED
	ROVIDER OR SUPPLIER		B. WIN	STREET A 12101 L			
BYRON I	HEALTH CENTER		FORT WAYNE, IN 46818				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	procedure, title Services Cove Medicaid" indic Incontinence capath soap were provided by Medicaid. In a note was indicacertain brand in listed, we will sonly charge yo between our charge yo between our chargested item instructions indicated was responsible difference for the facility branshopped for the The policy indicates and hygie upon request. Personal Hygie	red by Medicare and cated the both are and supplies and e covered items edicare and/or ddition, the following ated: "If you request a name of any items hop for that item and u the difference nosen item and your as." There were no licating the resident te for requesting the ne brand name versus and if the facility had a resident.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Q42511

Facility ID: 000255

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLI	ETED
		155364	B. WIN			10/10/	2012
	PROVIDER OR SUPPLIER HEALTH CENTER SUMMARY S	TATEMENT OF DEFICIENCIES		12101 L	ADDRESS, CITY, STATE, ZIP CODE LIMA RD VAYNE, IN 46818		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
F0167 SS=C	483.10(g)(1) RIGHT TO SURV ACCESSIBLE A resident has the results of the most facility conducted surveyors and an effect with respect. The facility must of for examination a readily accessible post a notice of the Based on interest the facility faile in an easily visolocation. This haffect all resides Finding includes 1. During the Enth of the facility, combetween 9:30 Asign was posted the main access stairwell and accindicating the seated in a whore receptionist/snashe knew when report was keptiness.	regit to examine the st recent survey of the by Federal or State y plan of correction in to the facility. make the results available and must post in a place to residents and must heir availability. view and observation, do to post survey results lible and accessible and the potential to ents in the facility. Environmental tour of ducted on 10/10/12 A.M 12:00 P.M., and do not a bulletin board in the shallway beside the cross from the elevator, that the survey results in the "lobby." resident who was	F01		F 167 Right to Survey Results – Readily Accessible What corrective actions (s) will be accomplished for those residents found to have been affected by the deficient practice. The binder has been changed to a white binder with black lettering so that it is easy to read. In addition, the binder will be located, free of chains, on the front counter in the lobby where the magazines are located. How other residents having the potential to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. All residents have the potential to be affected by our survey binder not being readily available for their review. The aforementioned corrective actions will cover all		11/08/2012

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Event ID: Q42511

Facility ID: 000255

If continuation sheet

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	OF CORRECTION OF CORRECTION 155364	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 10/10/2012			
	PROVIDER OR SUPPLIER HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
	The receptionist, Employee #13, indicated the report was kept in a dark blue three ring binder chained to the wall behind the receptionist/snack desk. The binder could not be removed, did not go all the way across the width of the desk so it could be accessed easily and read by residents and/or visitors. In addition, the binder was only labeled on the top in black letters. The unidentified resident, who was seated in her wheelchair by the snack desk, was queried if she could read the dark lettering on the dark blue binder when it was held up for her, and she indicated she could not make out the lettering. 3.1-3(b)(1)		residents. What measures will be put into place or what systemic changes who made to ensure that the deficient practice does not recur. The systemic change will be that whill no longer keep the binder secured to the wall but rather on the counter top free for all to take and read. How the corrective action(s) will the monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place. The front lobby staff will monitor the binder daily to ensure it is located at the front desk readily available for use. Please see attachment #1. The audits will be reviewed monthly at the QA meeting. This monitoring will occur for nine months.	re he pe			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155364	A. BUIL B. WINC			10/10/2012	
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t .			LIMA RD		
B∧D∪N F	HEALTH CENTER						
				FORT WAYNE, IN 46818			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL]			ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0279	483.20(d), 483.20						
SS=D	PLANS	PREHENSIVE CARE					
		e the results of the					
		evelop, review and revise					
		mprehensive plan of care.					
		develop a comprehensive					
		h resident that includes					
	-	ctives and timetables to					
		medical, nursing, and					
		nosocial needs that are omprehensive assessment.					
	identified in the Co	omprenensive assessment.					
	The care plan mu	ist describe the services					
	•	nished to attain or maintain					
	the resident's hig	hest practicable physical,					
		hosocial well-being as					
		483.25; and any services					
		vise be required under					
		not provided due to the					
		se of rights under §483.10,					
	§483.10(b)(4).	t to refuse treatment under					
		view, observation and	F027	79	F 279 Develop Comprehensi	V0	11/08/2012
		the facility failed to	102		Care Plans What corrective	<u>ve</u>	11/00/2012
	•	•			actions (s) will be		
	•	ans for facial hair for 2			accomplished for those		
		reviewed for ADL care			residents found to have been	,	
	plans. (Residei	nt #75, Resident #32)			affected by the deficient		
					practice. Both residents had		
	Findings includ	le:			their unwanted facial hair		
					removed. How other residen	ıts	
	1) Resident #7	75's record was			having the potential to be		
	reviewed 10/4/	2012 at 8:46 AM.			affect by the same deficient		
	Resident #75's	diagnoses included,			practice will be identified and		
		nited to, depression,			what corrective action(s) will be taken. All residents have to		
		arkinson's tremors.			potential to be affected by	. IC	
	aramao, and r	a			unwanted facial hair. All		
	During on ohea	on ation on 10/02/2012			residents were assessed for		
	שט an obse	ervation on 10/02/2012					

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Event ID: Q42511

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155364				10/10/2	2012
			B. WIN		ADDRESS CHEV STATE JID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
5) (5.6)					LIMA RD		
BYRON	HEALTH CENTER			FORT	NAYNE, IN 46818		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	at 8:57 AM, Re	esident #75 was			facial hair. Those residents fo	und	
	observed in the	e dining area. Long			with facial hair were asked if the	,	
		re obvious when sitting			wanted assistance removing the		
		e from the resident.			facial hair. At which point, the		
					facial hair was removed. Wha		
		the facility helped her			measures will be put into pla		
	_	acial hairs, Resident			or what systemic changes wi	'''	
		e had to ask for			be made to ensure that the deficient practice does not		
	assistance and	d it embarrassed her to			recur. Those residents who st	ato	
	ask.				a preference for facial hair	ale	
					removal will be care planned for	or	
	On 10/03/2012	2 at 8:35 AM Resident			assistance as needed. The		
	#75 was observed in the dining area				C.N.A. assignment sheets will		
		r. Long facial hair			reflect the resident's preference	e.	
	remained obvio	•			The in-service director will upo	late	
	remained obvid	ous.			the C.N.A. assignment sheet		
					based on resident condition ar		
	A Quarterly Mi	nimum Data Set (MDS)			any stated changes in preferei	nce	
	dated 7-25-20°	12 indicated Resident			concerning facial hair. Upon		
	#75 required o	ne person physical			admission, all residents will be	;	
	assistance to r	naintain personal			assessed by nursing staff for facial hair, preference. Any		
	hygiene includ	·			preferences for facial hair, and	,	
	, g.c	g Gristinig.			any required assistance with	'	
	L DN #2 provid	ed current CNA			facial hair removal will be		
					forwarded to the in-service		
		eet for review on			Director or her designee, who		
		8:53 AM. The CNA			updates the C.N.A. assignmer	nt	
	_	eet did not indicate			sheet, and the Care Plan team		
	Resident #75 v	vas to be assisted with			who updates the care plans. A		
	shaving.				nursing staff will be in-serviced	d on	
					the proper use of the C.N.A.		
	A Care plan tit	tled minimal assist for			assignment sheet to ensure ca is completed and resident	are	
		/10/12 included			preference for facial hair is		
		f encourage and praise			honored. Residents will be as	ked	
					quarterly, upon significant		
		with ADLs as ability			change, or as requested if the	ir	
		hower 2 x weekly,			preferences remain the same.		
		crease in ability,			Please see attachment #2.		
	observe for an	d assist in completion			How the corrective action(s)		

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Event ID: Q42511

Facility ID: 000255

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155364	B. WIN	IG		10/10/2012	
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER		12101 LIMA RD				
BYRON I	HEALTH CENTER			FORT V	VAYNE, IN 46818		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG			
	•	verbal cues and			will be monitored to ensure t		
		ots as needed, assist			deficient practice will not rec i.e., what quality assurance	ur	
		essing, toileting,			program will be put into place	e.	
	· ·	etc. as needed, assist			Nurse management will perfor		
	_	elt for transfers, PT/OT			10% audit of those residents w		
	as scheduled,	tab alarm in bed and			have stated a preference for		
	on chair, 1/2 S	R x 2. There was no			facial hair removal per the care	;	
	mention of ass	isting with facial hair			plan and C.N.A. assignment sheet. Results of the audit will	he	
	removal.				reviewed monthly at the QA		
					meeting. This monitoring will		
	In an interview	on 10/3/2012 at 8:10			occur for nine months.		
	AM, LPN #1 in	dicated facial care was					
	completed eve	ry morning by the					
	CNAs and any	long facial hairs					
	should be pluc	ked or shaved off. LPN					
	#1 further indic	ated Resident #75's					
	need to have fa	acial hair removed					
		een addressed in a					
	care plan.						
	caro piam						
	2.) Resident#	32's record was					
	,	2012 at 3:25 PM.					
		diagnosis included but					
	were not limited						
		ession, and seizure					
	disorder.						
	3,00,001.						
	Resident #32 v	vas observed					
		09:03:19 AM with					
		nore than stubbly.					
	_	ow often he was					
		ent #32 shrugged.					
	·	he wished to be					
		equently, Resident					
	#32 nodded.						

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Event ID: Q42511

Facility ID: 000255

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155364	B. WING		10/10/2012
NAME OF F	PROVIDER OR SUPPLIEI	· · · · · · · · · · · · · · · · · · ·		ADDRESS, CITY, STATE, ZIP CODE	
		•		LIMA RD	
BYRON I	HEALTH CENTER		FORT	WAYNE, IN 46818	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
TAG	During an obse at 3:19 PM facts shaved. An MDS dated Resident #32 of for all care. Care plans we 10-3-2012. No Resident #32's In an interview PM LPN #1 incomplete should have had indicating his resident CNA provided by LF 3:24 PM indications.	ervation on 10-3-2012 ial hair was not 8-21-2012 indicated was totally dependant re reviewed on care plan addressed a need to be shaved. on 10-3-2012 at 3:24 dicated Resident #32 ad a care plan	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE

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Event ID: Q42511

Facility ID: 000255

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155364	B. WING		10/10/2012
			_	ET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF P	ROVIDER OR SUPPLIER	L		01 LIMA RD	
BYRON I	HEALTH CENTER			RT WAYNE, IN 46818	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	483.20(k)(3)(ii) SERVICES BY Q CARE PLAN The services proving facility must be propersons in accord written plan of call Based on interview, the facility physician order for 1 resident of following lab or Findings included Resident #117' reviewed on 10. The record indicated a diagnosis of collect lower leg based of 8/29/12. On 8/30/12 a preceived to star milligrams (mg/8/30/12 then star daily starting or physician's order for a lab test for International Rathe Coumadin's done on 9/5/12	AUALIFIED PERSONS/PER Avided or arranged by the rovided by qualified dance with each resident's re. Aview and record dility failed to follow residents for laboratory tests of 3 reviewed for reders (Resident #117). Ale: As clinical record was 10/4/12 at 9:30 A.M dicated the resident had deep vein thrombosis ased on an ultra sound and thysician's order was rt Coumadin 7.5 for one dose on cart Coumadin 6 mg	1	CROSS-REFERENCED TO THE APPROPR	into
	An interview wi	ith LPN #10 on 10/4/12		on the new procedures relate Coumadin administration and	

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If continuation sheet

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STATEMEN	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
	155364	B. WING		10/10/2012		
			ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER	12101 LIMA RD				
BYRON	HEALTH CENTER	FORT \	WAYNE, IN 46818			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG		5.112		
	at 10:05 A.M. indicated the lab result		monitoring. Nurse Managers	I		
	for the PT/INR due on 9/5/12 could		implement a weekly monitoring	· .		
	not be located.		all new, routine, and changed medication orders for Couma			
			and corresponding labs. Plea			
	An interview with RN #11 on 10/4/12		see attachment #3. In addition	I		
	at 11:35 A.M. indicated the PT/INR		nurse management receives			
	ordered to be done 9/5/12 was never		weekly print out from the			
	completed. RN #11 indicated the		pharmacy of all residents on			
	l ·		Coumadin at which time, they	I		
	resident had been asymptomatic for		then ensure corresponding la	I		
	side effects related to an elevated		are ordered and obtained per			
	PT/INR level, no excessive bruising or		physician's order. How the corrective action(s) will be			
	bleeding. RN #11 indicated a		monitored to ensure the			
	physician's order had been received		deficient practice will not re	cur		
	to complete the lab test for a PT/INR		i.e., what quality assurance			
	on 10/5/12.		program will be put into place	ce.		
			All weekly monitoring of			
			corresponding lab reports will			
			reviewed at the monthly QA.	I		
			there were any discrepancies	I		
			found, a review of the correct			
			action taken will be discussed identify further systemic chan			
			needed. This monitoring will	yes		
			occur for nine months			
	3.1-35(g)(2)					
l		- 1	1			

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Event ID: Q42511

Facility ID: 000255

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		155364	B. WING 10/10/2012			
				ADDRESS CITY STATE TIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE		
DVD ON I	IEAL TH OFNITED			LIMA RD		
BYRON	HEALTH CENTER		FORT	WAYNE, IN 46818		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0312 SS=D	483.25(a)(3) ADL CARE PRO'RESIDENTS A resident who is activities of daily necessary service nutrition, groomin hygiene. Based on inter and observation ensure facial has a residents reversident #32, Findings included 1) Resident #32, Findings included 1) Resident #75's but were not limple arthritis, and Province at 8:57 AM, Resident were not limple at 8:57 AM, Resident hairs were across the table when asked if with her long fat #75 replied sheet	VIDED FOR DEPENDENT is unable to carry out living receives the less to maintain good ling, and personal and oral view, record review ling, the facility failed to lair was shaved for 2 of liviewed with facial hair. Resident #75)	F0312		n 11/08/2012 n 11/08/2012 n ts d I the dund they the exact acce till the exact acce to the exact acces to the exact ac	
	#75 was obser	at 8:35 AM Resident ved in the dining area r. Long facial hair		and any stated changes in preference concerning facial hair. Upon admission, all residents will be assessed by		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDDIG	00	COMPLETED	
		155364		LDING		10/10/2012	
			B. WIN		ADDRESS OFTW STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
D)/DOLL	IEAL TH OFFITER				LIMA RD		
BYRON	HEALTH CENTER			FORT	WAYNE, IN 46818		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	remained obvio	ous.			nursing staff for facial hair		
					preferences. Any preference	for	
	Λ Quarterly Mir	nimum Data Set (MDS)			facial hair, and any required		
	•	•			assistance with facial hair		
		12 indicated Resident			removal will be forwarded to the	ne	
	-	ne person physical			Inservice Director or her		
	assistance to n	naintain personal			designee, who updates the	41	
	hygiene includi	ing shaving.			C.N.A. assignment sheet, and		
					Care Plan team, who updates care plans. All nursing staff w		
	LPN #2 provide	ed current CNA			be in-serviced on the proper u		
	•	eet for review on			of the C.N.A. assignment shee		
	_	8:53 AM. The CNA			ensure care is completed and		
					resident preferences for facial		
	_	eet did not indicate			hair is honored. Residents wil	l be	
		vas to be assisted with			asked quarterly, upon significa	ant	
	shaving.				change, or as requested if the		
					preferences remain the same.		
	A Care plan, tit	tled minimal assist for			Those residents who state a		
	ADLs, dated 4/	/10/12 included			preference for facial hair remo	vai	
	•	f encourage and praise			will be care planned for assistance as needed. The		
		with ADLs as ability			C.N.A. assignment sheets will		
	•	hower 2 x weekly,			reflect the resident's preference		
		•			Please see attachment #2. Ho		
		crease in ability,			the corrective action(s) will b		
		d assist in completion			monitored to ensure the	-	
		verbal cues and			deficient practice will not rec	ur	
	physical promp	ots as needed, assist			i.e., what quality assurance		
	with meals, dre	essing, toileting,			program will be put into plac	e.	
		etc. as needed, assist			Nurse management will perfor	m a	
	· ·	elt for transfers, PT/OT			10% audit of those residents v	vho	
		tab alarm in bed and			have stated a preference for		
		R x 2. There was no			facial hair removal per the care	e	
	<i>'</i>				plan and C.N.A. assignment	16-	
		isting with facial hair			sheet. Results of the audit wil	i be	
	removal.				reviewed monthly at the QA		
					meeting. This monitoring will occur for nine months.		
	In an interview	on 10/3/2012 at 8:10			Coodi foi fillio filoritiis.		
	AM, LPN #1 in	dicated facial care was					
		ry morning by the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLE	TED
		155364	B. WIN			10/10/2	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹		12101 L	IMA RD		
BYRON I	HEALTH CENTER			FORT V	VAYNE, IN 46818		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	long facial hairs					
		ked or shaved off. LPN					
		cated Resident #75's					
	need to have fa	acial hair removed					
	should have be	een addressed in a					
	care plan.						
	,	32's record was					
		-2012 at 3:25 PM.					
	Resident #32's	diagnosis included but					
	were not limite	d to high blood					
	pressure,depre	ession, and seizure					
	disorder.						
	Resident #32 v						
		09:03:19 AM with					
		nore than stubbly.					
	When asked he	ow often he was					
	shaved, Reside	ent #32 shrugged.					
	When asked if	he wished to be					
	shaved more fr	requently, Resident					
	#32 nodded.						
	During an obse	ervation on 10-3-2012					
	at 3:19 PM fac	ial hair was not					
	shaved.						
	An MDS dated	8-21-2012 indicated					
	Resident #32 v	vas totally dependant					
	for all care.						
	Care plans we						
		care plan addressed					
	Resident #32's	need to be shaved.					

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Facility ID: 000255

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155364	B. WING		10/10/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				LIMA RD	
BYRON I	HEALTH CENTER		FORT	WAYNE, IN 46818	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		on 10-3-2012 at 3:24			
		licated Resident #32			
	should have ha	-			
	indicating his n	eed for care.			
		assignment sheet			
		N #1 on 10-3-2012 at			
		ted Resident #32 was			
		rith electric razor, but			
	not how often.				
	la an interniess	on 10 2 2012 -t 0:10			
		on 10-3-2012 at 8:10			
		dicated facial care was			
	· ·	ry morning by the			
		al hair should be			
	shaved off.				
	2.4.20/5\/2\				
	3.1-38(a)(3)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155364	A. BUILDING	00	10/10/2012
		195904	B. WING		10/10/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
BYRON	HEALTH CENTER			LIMA RD WAYNE, IN 46818	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	DROVIDED'S DI AN GE CODDECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0323 SS=D	The facility must environment rem hazards as is por receives adequal assistance device. Based on observation and the properly, to enfrom entrapmer residents review (Resident #67). Findings included the properly and the properly are properly and the properly are properly. Findings included the properly are properly are properly and the properly are properly as a properly are properly and the properly are properly are properly are properly are properly and the properly are properly ar	ensure that the resident sains as free of accident saible; and each resident te supervision and es to prevent accidents. Envation, interview and the facility failed to sees fit the bed sure the bed was free ent risk, for 1 of 4 ewed for mattress gaps b. de: n on 10/1/12 at 10:30 Resident #67's bed eave a 5" gap at the top even the mattress and en observation on 10.5 A.M. again noted a nother mattress and the top of the bed. with the Director of on 10/5/12 at 10:10 the facility had not p in the resident's bed fix the gap right away. Ited the facility had erous new beds in July esident #67's bed was	F0323	F 323 Free of Accident Hazards/Supervision/Devices What corrective actions (s) we be accomplished for those residents found to have been affected by the deficient practice. Resident #67 had homattress replaced with an 84" mattress. In addition, the facilipurchased a 4" mattress extended for the 84" mattress thus lengthening her mattress to a total of 88". How other residents having the potentiate to be affect by the same deficient practice will be identified and what corrective action(s) will be taken. All residents will have their mattresmeasured to ensure proper fit of the mattress to the head board/foot board. If a mattress found to be more than three inches shorter than the bed's head board and foot board, a inch extender will be added to mattress. What measures will be put into place or what systemic changes will be matto ensure that the deficient practice does not recur. All mattresses will have three income less total gap from headboard.	vill n er ity nder e ess ting s is four the II de

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155364	A. BUILDING B. WING	COMPLETED 10/10/2012
	PROVIDER OR SUPPLIER HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	Review of Resident #67's clinical record on 10-5-2012 at 10:45 AM indicated the resident had not suffered any accidents as a result of the gap between the mattress and the headboard since she received the new bed in July 2012. 3.1-45(a)(1)	to footboard with the addition four inch extender where needed. Any mattress purch in the future will also meet th same guidelines. The Direct Environmental Services, or h designee, will be responsible measuring the bed from headboard to footboard and ordering the appropriate size mattress based upon the bed measurement. Please see attachment #4. How the corrective action(s) will be monitored to ensure the deficient practice will not rei.e., what quality assurance program will be put into pla The Director of Environment Services, or his designee, will perform a 10% audit of reside beds to ensure the total gap measured between the headboard and footboard do not exceed three inches. Refor the audit will be reviewed monthly at the QA meeting, monitoring will occur for nine months.	ased ese or of is for d d d l ecur ce. al ll ent es sults This

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155364	B. WIN			10/10/	2012
(F of p			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			12101 L	IMA RD		
BYRON I	HEALTH CENTER		_	FORT V	VAYNE, IN 46818		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0329 SS=D	from unnecessary drug is any drug of dose (including dose (including dose (including dose (including)) or with for its use; or in the consequences where should be reduce combinations of the sased on a compart of the sased on intervent of the sased on i		F03	29	F 329 Drug Regimen is Free from Unnecessary Drugs Wrorrective actions (s) will be	nat	11/08/2012
					accomplished for those		
		of medication for sleep			residents found to have been	ı	
		dequately monitor a			affected by the deficient		
		ing Coumadin, for 2 of			practice. Resident #68 did no		
		viewed for medications			have her Behavior Intervention	1	
	(Residents #68	and #117).			Monthly Flow Sheet (BIMF) initiated to document behavior		
	Findings includ				interventions which occurred p to PRN medication administration. Her BIMF has	ПОГ	
	1. Resident #6	8's clinical record was			since been started. Resident		
	reviewed on 10	0/3/12 at 11:00 A.M.			117 had Coumadin held and la taken the next morning. How	ıbs	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLET	ED
		155364	B. WIN			10/10/20	012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				-IMA RD		
BYRON I	HEALTH CENTER				WAYNE, IN 46818		
					, iii 40010		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE (COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident #68's	diagnoses included			other residents having the		
	but were not lir	nited to insomnia,			potential to be affect by the		
	bipolar disorde	r, and diabetes. The			same deficient practice will be		
	record indicate	d the resident had a			identified and what correctiv	е	
	new nhysician's	s order from 9/6/12 for			action(s) will be taken. All		
		illigrams (mg) at			residents have the potential to affected by failing to monitor	be	
	1	,			behavior interventions prior to		
	bedtime as nee	cueu (FRIN) IUI			administering a PRN psychotr		
	insomnia.				medication. Nurse Managers		
					audit all resident M.A.R.'s for		
	The resident's	Medication			PRN psychotropic medications	s	
	Administration	Record (MAR) for			and ensure corresponding BIN	∕lF's	
	9/12 included a	Behavior/Intervention			are in place. If a PRN is found	d to	
		ecord which indicated			not have a BIMF, one will be		
		to "chart interventions			started immediately. Please s		
					attachment #5. All residents v	vho	
	before giving P				are on Coumadin have the		
		vere numbered 1			potential to be affected by faili to follow physician's orders for		
	through 17: In				tests. Nurse management	lab	
	indicated PRN	medication (should not			reviewed all lab orders for all		
	be first interver	ntion).			residents receiving Coumadin		
					Any discrepancy found would		
	Review of the r	resident's (MAR)			have been addressed		
		esident received			immediately. Please see		
		g at bedtime on 6			attachment #3. What measur	es	
	,	•			will be put into place or what	t	
		5 of the 6 occasions of			systemic changes will be ma	ide	
	receiving Bena				to ensure that the deficient		
	•	logical interventions			practice does not recur. All		
	were attempted	d before administering			licensed nursing staff will be		
	the medication	(9/9/12; 9/13/12;			in-serviced on the requiremen	t to	
	9/17/12; 9/19/1	2; 9/22/12).			document behavioral		
	, ,	,			interventions attempted prior t administering PRN psychotrop		
	An interview wi	ith RN #11 on 10/3/12			medication. Nurse manager's		
	at 2:30 P.M. in				implement a weekly monitorin		
					all new, routine, and changed	9 01	
		logical interventions			medication orders for Coumac	_{din}	
		een attempted on all			and corresponding labs. Plea		
	occasions for in	nsomnia before			see attachment #3. In addition		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLE	ETED
		155364	A. BUII B. WIN			10/10/2	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			LIMA RD		
BYBON F	HEALTH CENTER				VAYNE, IN 46818		
			1		VATIVE, IIV 40010		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		of Benadryl 50 mg in			nurse management receives a	l	
	September 201	12.			weekly print out from the pharmacy of all residents on		
					Coumadin at which time, they		
	2. Resident #1	17's clinical record			then ensure labs are ordered a	and	
	was reviewed	on 10/4/12 at 9:30			obtained per physician's order		
	A.M The reco	rd indicated the			How the corrective action(s)		
	resident had a	diagnosis of deep vein			will be monitored to ensure t		
		lower leg based on an			deficient practice will not rec	ur	
	ultra sound of 8	•			i.e., what quality assurance		
		5/20/ 12.			program will be put into plac		
	On 0/20/12 a n	hygigian's order was			Nurse management will perfor 10% audit of those residents w		
	-	hysician's order was			have a BIMF and PRN	VIIO	
		rt Coumadin (a blood			psychotropic medication to		
	_	ation) 7.5 milligrams			ensure behavior interventions		
	` • ,	ose on 8/30/12 then			occur prior to medication. Res	ults	
	start Coumadir	n 6 mg daily starting on			of the audit will be reviewed		
	8/31/12. A phys	sician's order was also			monthly at the QA meeting. T	his	
	received for a l	ab test for a			monitoring will occur for nine		
	Prothrombin Ti	me/ International Rate			months. All weekly monitoring		
	(PT/INR) to mo	onitor the Coumadin's			lab reports will be reviewed at monthly QA. If there were any		
	,	to be done on 9/5/12.			discrepancies found, a review		
		ecord indicated the			the corrective action taken will		
		t been completed. No			discussed to identify further		
		en completed since			systemic changes needed. Th	nis	
		-			monitoring will occur for nine		
	i ii c priysicialis	order on 8-30-2012.			months		
	Am imtamai	th I DN #40 40/4/40					
		ith LPN #10 on 10/4/12					
		ndicated the lab result					
		due on 9/5/12 could					
	not be located.						
	An interview w	ith RN #11 on 10/4/12					
	at 11:35 A.M. i	ndicated the PT/INR					
	ordered to be	done 9/5/12 was never					
	completed RN	#11 indicated the					
	•	een asymptomatic for					
		son asymptomatic for					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
155364		B. WING	10/10/2012				
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(X5) COMPLETION DATE			
	side effects rel PT/INR level, i bleeding. RN physician's ord to complete th on 10/5/12 to r	ated to an elevated no excessive bruising or #11 indicated a der had been received e lab test for a PT/INR	TAU TAU	DEFICIENCY)	DATE		

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Event ID: Q42511

Facility ID: 000255

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	of correction	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/10/2012
	PROVIDER OR SUPPLIER HEALTH CENTER	12101	ADDRESS, CITY, STATE, ZIP CODE LIMA RD WAYNE, IN 46818	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses Licensed practical nurses or licensed vocational nurses (as defined under State law) Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on interview and record review, the facility failed to post nurse	F0356	F 356 Posted Nurse Staffing Information What corrective	
	staffing in a prominent location for visitor and resident review. This had the potential to affect all residents and/or residents families and visitors		actions (s) will be accomplished for those residents found to have bee affected by the deficient practice. The nurse staffing	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING 00		00	COMPLETED	
		155364	A. BUILDING			10/10/2012	
		1	B. WIN				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
				_	IMA RD		
BYRON I	HEALTH CENTER			FORT V	VAYNE, IN 46818		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	in the facility.	in the facility.			information will be posted in th	e	
	ĺ				front lobby. How other		
	Finding include	76.		residents having the poter		ıl 📗	
	i mamg morade				to be affect by the same		
	Duraina au Albana a ann a	:			deficient practice will be		
	_	ironmental tour of the			identified and what corrective	e	
	•	ted on 10/10/12			action(s) will be taken. All		
	-	A.M 12:00 P.M., the			residents have the potential to	be	
	nursing staffing	g posting could not be			affected by the nurse staffing	_	
	located in the f	ront lobby of the facility			information being posted on the nurse supervisor's door. The	c	
	or at the nurse's stations on the three			nurse supervisor's door. The nurse staffing information will now			
	floors of the fac	cility		be posted in the front lobby.			
	noors of the facility.			What measures will be put into			
	Links with the NA stark was an			place or what systemic			
	Interview with Maintenance				changes will be made to		
	supervisor, on 10/10/12 at 9:30 A.M.,			ensure that the deficient			
	indicated he did not know where			practice does not recur. During			
	nursing staffing was posted but			normal business hours, the			
	thought it was on the staffing office				scheduler will be responsible f	or	
	door located or	n the first floor halfway			updating the nursing staffing		
	to the kitchen area. Observation of the nursing staff development office door, located on unit 11 hall, approximately 1/2 way down from the nurse's station and				information. During off hours, the		
					nurse supervisor will be		
					responsible for posting the		
					nursing hours located in the fro	ont	
					lobby. How the corrective		
					action(s) will be monitored to	'	
					ensure the deficient practice		
	main elevator bank, indicated a		will not recur i.e., what quality				
	posting taped to the outside of the		assurance program will be put into place. The front lobby staff				
	staff development office door. The		will monitor the staffing hours to				
	door was covered with all kinds of		ensure they are updated and				
	staff information. The location of the staff posting was complete but was not located in a				posted per Federal guidelines.		
					Please see attachment # 6.		
					The audits will be reviewed		
					monthly at the QA meeting. T	his	
					monitoring will occur for nine		
	prominent loca	tion easily viewed by			months.		
	residents and/or visitors.						

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PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155364	(X2) MULTIPLE CO A. BUILDING B. WING	00 	COMPI		
NAME OF PROVIDER OR SUPPLIER BYRON HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 12101 LIMA RD FORT WAYNE, IN 46818				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE DEFICIENCY)	PRRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
	3.1-13(a)						

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